

		FOR OHF USE					

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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0045005</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>River Bluffs of Cahokia</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>05/01/2000</u> to <u>12/31/2000</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>3354 Jerome Lane</u> <u>Cahokia</u> <u>62206</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>St. Clair</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
<b>Telephone Number:</b> <u>(618 ) 337-9823</u> <b>Fax #</b> <u>( 618 ) 332-1811</u>		<b>Paid Preparer</b> (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin &amp; Glasser LLP</u> <u>One South Wacker Drive</u> <u>Chicago, IL 60606-3392</u> (Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
<b>IDPA ID Number:</b> <u>371395559001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> Phone # <b>(217) 782-1630</b>	
<b>Date of Initial License for Current Owners:</b> <u>05/01/2000</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
<b>IRS Exemption Code</b> _____			
<input checked="" type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input checked="" type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<b>GOVERNMENTAL</b>			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Michael G. Kaplan</u> <b>Telephone Number:</b> <u>312-634-3400</u> <u>Altschuler, Melvoin &amp; Glasser LLP</u> <u>One South Wacker Drive</u> <u>Chicago, IL 60606-3392</u>			

Please send copies of any desk review or audit adjustments to the above address.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number River Bluffs of Cahokia# 0045005 Report Period Beginning: 05/01/2000 Ending: 12/31/2000

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds 05/01/2000

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>49</u>	Skilled (SNF)	<u>49</u>	<u>12,005</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>81</u>	Intermediate (ICF)	<u>81</u>	<u>19,845</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>130</u>	TOTALS	<u>130</u>	<u>31,850</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,055</u>		<u>1,378</u>	<u>7,433</u>	8
9	SNF/PED					9
10	ICF	<u>15,957</u>	<u>1,110</u>	<u>398</u>	<u>17,465</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,012</u>	<u>1,110</u>	<u>1,776</u>	<u>24,898</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 78.17%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been  
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 05/01/2000

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 05/01/2000NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 20 and days of care provided 1,063Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH\* ☐CASH\* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

River Bluffs of Cahokia

# 0045005

Report Period Beginning:

05/01/2000

Ending:

12/31/2000

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	82,691	26,697	3,736	113,124		113,124		113,124		1
2	Food Purchase		61,839		61,839		61,839	(2,238)	59,601		2
3	Housekeeping	49,394	5,005		54,399		54,399		54,399		3
4	Laundry	25,365	5,628		30,993		30,993		30,993		4
5	Heat and Other Utilities			41,432	41,432		41,432		41,432		5
6	Maintenance	28,049	6,113	26,330	60,492		60,492		60,492		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	185,499	105,282	71,498	362,279		362,279	(2,238)	360,041		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,000	4,000		4,000		4,000		9
10	Nursing and Medical Records	654,604	61,047	1,640	717,291		717,291		717,291		10
10a	Therapy			45,648	45,648		45,648		45,648		10a
11	Activities	26,811	1,726	500	29,037		29,037		29,037		11
12	Social Services	7,768		4,333	12,101		12,101		12,101		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	689,183	62,773	56,121	808,077		808,077		808,077		16
	<b>C. General Administration</b>										
17	Administrative	26,037		52,000	78,037		78,037		78,037		17
18	Directors Fees										18
19	Professional Services			53,893	53,893		53,893	(2,750)	51,143		19
20	Dues, Fees, Subscriptions & Promotions			8,091	8,091		8,091	(50)	8,041		20
21	Clerical & General Office Expenses	47,767		29,643	77,410		77,410		77,410		21
22	Employee Benefits & Payroll Taxes			127,489	127,489		127,489	1,663	129,152		22
23	Inservice Training & Education										23
24	Travel and Seminar			651	651		651		651		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			34,435	34,435		34,435		34,435		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	73,804		306,202	380,006		380,006	(1,137)	378,869		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	948,486	168,055	433,821	1,550,362		1,550,362	(3,375)	1,546,987		29

\* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

\*\* See schedule of adjustments attached at end of cost report.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number

River Bluffs of Cahokia

#0045005

Report Period Beginning:

05/01/2000

Ending:

12/31/2000

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			1,304	1,304		1,304		1,304			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,626	27,626		27,626		27,626			32
33	Real Estate Taxes			22,300	22,300		22,300		22,300			33
34	Rent-Facility & Grounds			230,923	230,923		230,923		230,923			34
35	Rent-Equipment & Vehicles			5,087	5,087		5,087		5,087			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			287,240	287,240		287,240		287,240			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			915	915		915		915			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,775	47,775		47,775		47,775			42
43	Other (specify):* <b>Nonallowable costs</b>			2,470	2,470		2,470	(2,470)				43
44	<b>TOTAL Special Cost Centers</b>			51,160	51,160		51,160	(2,470)	48,690			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	948,486	168,055	772,221	1,888,762		1,888,762	(5,845)	1,882,917			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\* See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number River Bluffs of Cahokia

# 0045005

Report Period Beginning:

05/01/2000

Ending:

12/31/2000

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(521)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,750)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,949)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(625)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (5,845)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	-		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (5,845)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1		1
2		2
3		3
4		4
5		5
6		6
7		7
8		8
9		9
10		10
11		11
12		12
13		13
14		14
15		15
16		16
17		17
18		18
19		19
20		20
21		21
22		22
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68		68
69		69
70		70
71		71
72		72
73		73
74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90 Total	0	90

Facility Name &amp; ID Number River Bluffs of Cahokia

# 0045005

Report Period Beginning: 05/01/2000 Ending: 12/31/2000

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Moshe David Aryeh	100.00%	Anna Henry Nursing & Rehabilitation Center	Edwardsville			
		Elmwood Nursing & Rehabilitation Center	Maryville			
		Royal Heights Nursing & Rehabilitation Center	Bellville			
		Salem Village Nursing & Rehabilitation Center	Joliet			
		Grand Manor Nursing & Rehabilitation Center	St Louis, MO			
		Northview Village	St Louis, MO			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number River Bluffs of Cahokia # 0045005 Report Period Beginning: 05/01/2000 Ending: 12/31/2000

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Moshe David Aryeh	Owner	Administrative	100.00%		40	100.00		\$ ***52,000	L17, C3	1
2											2
3		Anna Henry Nursing & Rehab Center		0.00%	15,838	0					3
4		Elmwood Nursing & Rehabilitation Center		0.00%	15,514	0					4
5		River Bluffs of Cahokia - pre 5/1/00		0.00%	5,097	0					5
6		Royal Heights Nursing & Rehab Center		0.00%	21,958	0					6
7		Salem Village Nursing & Rehab Center		0.00%	20,443	0					7
8		Grand Manor Nursing & Rehab Center		0.00%	6,000	0					8
9		Northview Village		0.00%	24,000	0					9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

\*\*\* - Management Fees Paid

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number River Bluffs of Cahokia# 0045005

Report Period Beginning:

05/01/2000Ending: 2/31/2000

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_Fax Number ( ) \_\_\_\_\_

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8  Facility Units	9  Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8	N/A									8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$		\$			\$		1					
2														2					
3														3					
4														4					
5														5					
	Working Capital																		
6	Manufacturer's Bank		x	Working capital	Interest Only	5/4/2000		390,000	390,000	05/04/2001	0.1150		27,626	6					
7														7					
8														8					
9	TOTAL Facility Related							\$ 390,000	\$ 390,000			\$ 27,626	9						
	B. Non-Facility Related*																		
10														10					
11														11					
12														12					
13														13					
14	TOTAL Non-Facility Related							\$		\$			\$	14					
15	TOTALS (line 9+line14)							\$ 390,000	\$ 390,000			\$ 27,626	15						

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **River Bluffs of Cahokia**# **0045005** Report Period Beginning: **05/01/2000** Ending: **12/31/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	17,834	2
3. Under or (over) accrual (line 2 minus line 1).	\$	17,834	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	4,466	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	22,300	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995		8
	1996		9
	1997	25,798	10
	1998	26,751	11
	1999	31,858	12

	<b>FOR OFF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

1999 taxes	31,858
Increase of .05	x 1.05% x 8 months
	22,300

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**SEE ACCOUNTANTS' COMPILATION REPORT**

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Windows		2000		52,035	650	40	650		650	9
10	Wander Alarm System		2000		16,781	210	40	210		210	10
11	Light Fixtures		2000		1,989	25	40	25		25	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 70,805	\$ 885		\$ 885	\$	\$ 885	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$	\$	\$	\$		\$	37
38	Current Year Purchases	8,369	419	419		10	419	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 8,369	\$ 419	\$ 419	\$		\$ 419	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 79,174	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 1,304	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 1,304	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,304	51

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: First Health Care Associates

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		130	5/1/00	\$ 230,923			3
4	Additions							4
5								5
6								6
7	TOTAL		130		\$ 230,923			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

5th year - purchase price - \$4,290,000

9. Option to Buy: ☒ YES ☐ NO Terms: 10th year purchase price - \$4,150,000

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 5,087 Description: Photocopier - \$ 4565, Postage machine - \$ 522

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 05/01/2000

Ending 05/01/2010

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/2001 \$ 359,434

13. 12/2002 \$ 373,669

14. 12/2003 \$ 387,904

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>It is the policy of this facility to only hire certified nurses aides.</i> If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**



**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	387	\$ 21,305	\$	387	\$ 21,305	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		7	391		7	391	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		422	23,192		422	23,192	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Radiology Other (specify):   Laboratory	L39, C3 L39, C3					576 339		576 339	13
14	TOTAL			\$	816	\$ 44,888	\$ 915	816	\$ 45,803	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 105,241	\$ 105,241	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>none</u> )	391,004	391,004	3
4	Supply Inventory (priced at <u>                    </u> )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	61,897	61,897	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 558,142	\$ 558,142	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	70,805	70,805	15
16	Equipment, at Historical Cost	8,369	8,369	16
17	Accumulated Depreciation (book methods)	(1,304)	(1,304)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): <u>Option to Buy</u>	130,000	130,000	22
23	Other(specify): <u>Due from HMA</u>	61,222	61,222	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 269,092	\$ 269,092	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 827,234	\$ 827,234	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 284,661	\$ 284,661	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	390,000	390,000	29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	2,415	2,415	31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,466	4,466	32
33	Accrued Interest Payable	4,086	4,086	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	40,853	40,853	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 726,481	\$ 726,481	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 726,481	\$ 726,481	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 100,753	\$ 100,753	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 827,234	\$ 827,234	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>100,753</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 100,753</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 100,753</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 1,988,840	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,988,840	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Schedules 19A</u>	675	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 675	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,989,515	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	362,279	31
32	Health Care	808,077	32
33	General Administration	380,006	33
	<b>B. Capital Expense</b>		
34	Ownership	287,240	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	3,385	35
36	Provider Participation Fee	47,775	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,888,762	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	100,753	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 100,753	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Cash basis tax return.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number River Bluffs of Cahokia# 0045005Report Period Beginning: 05/01/2000Ending: 12/31/2000

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,431	1,559	\$ 43,734	\$ 28.05	1
2	Assistant Director of Nursing	20	20	281	14.05	2
3	Registered Nurses	4,199	4,406	69,982	15.88	3
4	Licensed Practical Nurses	11,882	12,380	191,141	15.44	4
5	Nurse Aides & Orderlies	37,616	40,355	336,270	8.33	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	781	888	14,333	16.14	9
10	Activity Assistants	1,301	1,481	12,478	8.43	10
11	Social Service Workers	356	405	7,768	19.18	11
12	Dietician					12
13	Food Service Supervisor	1,923	1,963	14,451	7.36	13
14	Head Cook	4,143	4,420	31,164	7.05	14
15	Cook Helpers/Assistants	4,924	5,251	37,076	7.06	15
16	Dishwashers					16
17	Maintenance Workers	2,259	2,515	28,049	11.15	17
18	Housekeepers	8,717	9,499	49,394	5.20	18
19	Laundry	4,052	4,195	25,365	6.05	19
20	Administrator	1,272	1,304	26,037	19.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,884	1,920	19,333	10.07	23
24	Clerical	2,716	2,748	28,434	10.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,070	2,134	13,196	6.18	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	91,546	97,443	\$ 948,486 *	\$ 9.73	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	110	\$ 3,736	L1, C3	35
36	Medical Director	Monthly	4,000	L9, C3	36
37	Medical Records Consultant	16	640	L10, C3	37
38	Nurse Consultant	Monthly	400	L10, C3	38
39	Pharmacist Consultant	Monthly	600	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	19	760	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	500	L11, C3	44
45	Social Service Consultant	51	4,333	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	196	\$ 14,969		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Mary Nettemeyer	Administrator	0.00%	\$ 19,057	Workers' Compensation Insurance	\$ 30,670	IDPH License Fee	\$ 1,200		
Kim Schrumke	Administrator	0.00%	6,980	Unemployment Compensation Insurance	8,894	Advertising: Employee Recruitment	915		
				FICA Taxes	71,754	Health Care Worker Background Check			
				Employee Health Insurance	14,799	(Indicate # of checks performed 40 )	480		
				Employee Meals	1,663	IL Dept of Professional Registration	75		
				Illinois Municipal Retirement Fund (IMRF)*		IL Council on Long-term Care	4,017		
				Other	1,372	Misc Subscriptions	554		
						IRS filing fee	800		

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

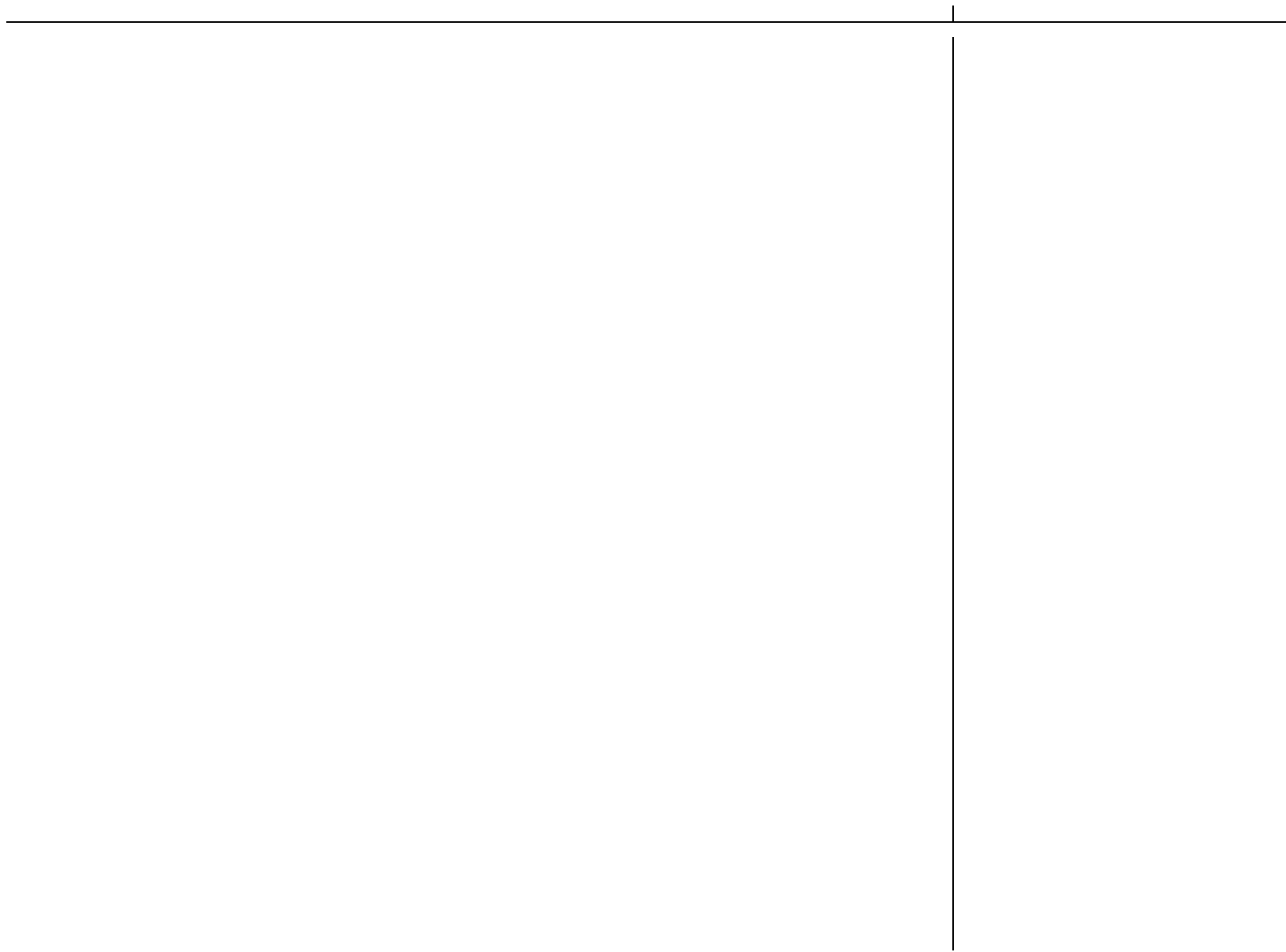
1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4	N/A												
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18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

<p><b>Facility Name &amp; ID Number</b>   <u>River Bluffs of Cahokia</u></p> <p><b>XX. GENERAL INFORMATION:</b></p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union?      <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report?      <u>Yes</u>  If YES, give association name and amount.      <u>IL Council on LTC - \$ 4,017</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization?      <u>No</u>      If YES, have these costs been properly adjusted out of the cost report?      <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?      <u>No</u>      If YES, what is the capacity?      <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases?      <u>Yes</u>  What was the average life used for new equipment added during this period?      <u>10</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.      \$ <u>None</u>      Line <u>N/A</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?      <u>Yes</u>      If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement?      <u>No</u>  If YES, give effective date of lease.      <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement?      YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>X</u> NO      If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  <u>River Bluffs of Cahokia Nursing &amp; Rehabilitation Center - # 0042713, 5/1/00</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.      \$ <u>47,775</u>  This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?      <u>No</u>      If YES, attach an explanation of the allocation.</p>	<p style="text-align: center;"><b>STATE OF ILLINOIS</b></p> <p>#      <u>0045005</u>      Report Period Beginning:      <u>05/01/2000</u>      Ending:      <u>12/31/2000</u></p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?      <u>Yes</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u>      For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.      \$ <u>1,663</u>      Has any meal income been offset against related costs?      <u>No</u>      Indicate the amount.      \$ <u>N/A</u></p> <p>(16) Travel and Transportation  a. Are there costs included for out-of-state travel?      <u>No</u>  If YES, attach a complete explanation.  b. Do you have a separate contract with the Department to provide medical transportation for residents?      <u>No</u>      If YES, please indicate the amount of income earned from such a program during this reporting period.      \$ <u>N/A</u>  c. What percent of all travel expense relates to transportation of nurses and patients?      <u>None</u>  d. Have vehicle usage logs been maintained?      <u>N/A</u>  e. Are all vehicles stored at the nursing home during the night and all other times when not in use?      <u>N/A</u>  f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?      <u>N/A</u>  <b>g. Does the facility transport residents to and from day training?      <u>No</u></b>  <b>Indicate the amount of income earned from providing such transportation during this reporting period.      \$ <u>N/A</u></b></p> <p>(17) Has an audit been performed by an independent certified public accounting firm?      <u>No</u>  Firm Name:      <u>N/A</u>      The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?      <u>N/A</u>      If no, please explain.      <u>N/A</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?      <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?      <u>Yes</u>  Attach invoices and a summary of services for all architect and appraisal fees.</p>
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**SEE ACCOUNTANTS' COMPILATION REPORT**





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